MARYLAND BOARD OF PHYSICIANS

P.O. BOX 37217, BALTIMORE, MD 21297

410-764-4777; 1-800-492-6836

FOR BANK USE ONLY

DATE:_____/_____/ 20___

CHECK NUMBER:_____

AMT PAID: $ _____

NAME CODE:_____

APPID: 50

APPLICATION FOR REPLACEMENT LICENSE AND WALL CERTIFICATE FOR ALLIED HEALTH PRACTITIONERS

License fee: $25
Wall certificate fee: $75

Instructions:
(1) Complete the application.
(2) Include a check or money order made **payable to the Maryland Board of Physicians** in the appropriate fee.
(3) **Circle replacement requested for**: **a**. License/registration card **b**. Wall certificate **c**. Both.
(4) **Circle reason for request**: **a**. Lost **b**. Stolen **c**. Damaged **d**. Name misspelled **e**. Never received
(5) Attach copies of supporting documents for stolen license/wall certificate (e.g. insurance loss claim, police report). In case of damage or mutilation, attach damaged for fragmented license/wall certificate.
(6) Have application notarized.

License Number

Social Security Number (For identification purposes only)

Last Name and Generational Indicator (Jr., III. etc.)

First Name and Middle Name/ Initial

Address (Apartment Number, Suite Number or C/O)

Address (Street Address)

City

State

Zipcode

Date of Birth

Telephone Number

Sex M F

I solemnly affirm under the penalties of perjury that the contents of the foregoing paper are true and correct to the best of my knowledge, information and belief.

Signature _____ Date _____

THIS FORM MUST BE NOTARIZED.

_____
Notary Public

Date: _____
City/County of Residence:_____
Commission Expires:_____